Selected mental disorders - symptoms, diagnosis

(Wybrane zaburzenia psychiczne – objawy, rozpoznanie)

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Abstract – Introduction: Explaining the nomenclature and interpreting the symptoms of mental disorders is not possible without knowing the culture and social context, because what will be seen as a disease in some societies can be described as possession in others. One can be tempted to state that mental illness is not only an objective state, but can be a social label given to people who break accepted norms in a given society.
Aim of the study. The aim of this study was to present the symptoms and diagnosis of selected mental disorders.
Selection of material. The search was conducted in the Scopus database using the terms depression, schizophrenia, bipolar affective disorder, neurological disorders (anxiety disorders), symptoms, diagnosis 1982-2018. The literature found in the Google Scholar database was analysed for the highest number of citation. The literature selected in this way was used as the material for this study.
Conclusions. Due to the similarity of somatic symptoms of many mental disorders, these states should be differentiated very carefully. This applies first and foremost to rescue/rescue departments - especially in cases of first-time/beginning symptoms.

Key words **-** depression, schizophrenia, bipolar affective disorder, neurological disorders, symptoms, diagnosis.

Streszczenie – Wstęp. Wyjaśnienie nazewnictwa i interpretacja objawów zaburzeń psychicznych nie jest możliwa bez znajomości kultury i kontekstu społecznego, ponieważ to co w jednych społeczeństwach będzie postrzegane jako choroba, w innych może być określone jako opętanie. Można się pokusić o stwierdzenie, że choroba psychiczna jest nie tylko obiektywnym stanem ale może być etykietą społeczną nadaną osobom łamiącym przyjęte w danym społeczeństwie normy.
Cel pracy. Celem pracy było przedstawienie objawów i rozpoznania wybranych zaburzeń psychicznych.
Dobór materiału. Poszukiwania przeprowadzono w bazie Scopus używając pojęć *depresja, schizophrenia, zaburzenie afektywne dwubiegunowe, zaburzenia nerwicowe (zaburzenia lękowe), objawy, rozpoznanie* 1982-2018r. Znalezione piśmiennictwo w bazie Google Scholar przeanalizowano pod kątem największej liczby cytowań. Tak wyselekcjonowane piśmiennictwo posłużyło za materiał do opracowania niniejszej pracy.
Wnioski. Ze względu na podobieństwo somatycznych objawów wielu zaburzeń psychicznych należy bardzo wnikliwie różnicować te stany. Przede wszystkim dotyczy się to oddziałów ratunkowych/izby przyjęć - szczególnie w przypadkach pierwszorazowych/początkowych objawów.

Słowa kluczowe – depresja, schizophrenia, zaburzenie afektywne dwubiegunowe, zaburzenia nerwicowe, objawy, rozpoznanie.

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I. INTRODUCTION

Mental illnesses occur in both historically known and contemporary societies and cultures. Their forms, characters and names can vary, as can their image in social consciousness, shaped by worldview systems trying to explain physical, social and spiritual reality. The World Health Organization defines health as "the fullness of physical, mental and social well-being, not only the absence of illness or disability". [1,2]

Menninger defined mental health as the adaptation of man to the world and other people with maximum efficiency and happiness. [3]

Mental health is defined as the absence of mental illness or psychopathological symptoms, balance in physiological processes of stimulation and inhibition, dynamic biochemical homeostasis in mental processes or the absence of defects in mental structure and functions. In psychological definitions, on the other hand, the features of a mentally healthy person are: ability of comprehensive development and self-fulfilment, self-acceptance, self-esteem, autonomy and identity, dynamic balance of personality factors, ability to achieve optimal happiness and satisfaction with life, ability to play, love, work, effective realization of own goals or realistic perception of reality. Sociologists in the definition of mental health focus on the assessment of a person's ability to adapt to changing conditions, the ability to live together in a group and to function properly in social roles and to effectively perform these social roles. [4-7]

Defining mental illness is not easy because, unlike somatic diseases, where it is possible to determine certain objective changes in the body, in the case of mental illness the criteria for diagnosis may be blurred and the diagnostic process may never end. [8]

Explaining the nomenclature and interpreting the symptoms of mental disorders is not possible without knowing the culture and social context, because what will be seen as a disease in some societies can be described as possession in others [5-7,9]. One may be tempted to state that mental illness is not only an objective state, but may be a social label given to people who break accepted norms in a given society. Mental health is one of the most important resources of modern society. The presence of a mental disorder stigmatizes the daily functioning of every person, regardless of age, gender or potential. [10]

I. DEPRESSION

The word "depression" in everyday language is often used as a synonym for sadness. Its medical term refers to many psychopathological symptoms. No factor has been proven to trigger depression itself. Rather, many factors interact with each other, and potentially depressurizing features are opposed. A single factor associated with life events can trigger depression as a last resort only if there is a particular individual susceptibility.[11,12] It seems important that depressive disorders can be caused by physiological factors and be closely related to the life cycle of men and women. For example, the successive stages of life and the undertaking of reproductive functions in women are closely related to changing estrogen concentrations. Fluctuations in the concentration of these hormones can significantly affect the risk of depressive episodes or even a recurrence of depression. Mood reduction is most often described by patients as sadness, depression, and sometimes as inability to experience joy (anhedonia). Mood disorders can be so deep that patients lose the ability to cry and complain about their inability to experience joy and sadness (depressive indifference). [13] Additional symptoms include: unreasonable guilt, complaints about cognitive disorders, thoughts of resignation or suicidal thoughts and tendencies, agitation or inhibition, anxiety, somatic complaints and biological rhythm disorders. 14]

Anxiety, the intensity of which usually changes in waves, can appear suddenly and for no apparent reason as a panic attack. It can also be a secondary reaction to the disease itself. The patient is usually located in the pre-cardiac area or in the abdomen. It may be accompanied by neurological symptoms typical for anxiety disorders. [13] Depressed people require particularly careful care of their immediate surroundings, because: Depressed people have a negative opinion of their past, achievements, themselves, health, and have a pessimistic view of the present and future (Beck's so-called Depressive Triad). They feel worthless and consider their state of health as hopeless, which in extreme cases causes depressive delusions. [13] The sick consider that what they are facing is punishment for the sins of the past (delusions of punishment, sinfulness, guilt), or sometimes claim to be sick with a fatal illness. The basis of any effective treatment of depressive patients is a compassionate, understanding emotional attitude towards the patient. Patience and a positive attitude towards the future are important qualities that should be communicated to the patient. [12]

III. SCHIZOPHRENIA

The term schizophrenia was not introduced until 1911 by Eugen Bleuler, who noted that schizophrenia is an uneven disease, but a group of disorders with certain common characteristics, called axial symptoms. [15] Schizophrenia is considered to be one of the most serious mental illnesses. The severity of the disease results from the fact that the symptoms of schizophrenia tend to knock the patient out of normal functioning, are difficult to bear for the patient and his environment, and the course of the disease is often chronic, with periods of improvement and exacerbation, with exacerbations of the disease not associated with any specific external or internal factors. [9,10,14,15]. Such unpredictability of the disease generates anxiety, a sense of lack of control over life, disease, and behaviour both in the patient and his environment. Among many concepts of disease development, it is stressed that schizophrenia is regression to the narcissistic stage or even deeper. It is indicated that the family environment and the atmosphere in it (emotional climate) may adversely affect the development of personality through lack of emotional acceptance, through frequent experiencing fear. [10,15,16]

This disease is characterized by psychotic symptoms, among which there are: disorders of thinking, affect and behavior. They often result in disorganization of mental life, worse functioning in social life. Schizophrenia gives disturbances in thinking and perception, as well as maladjustment and shallow affect. The clear consciousness and efficiency of the intellect are usually preserved, although over time some cognitive deficits may appear. The most important psychopathological symptoms include: echoes of thoughts, sending and collecting thoughts, revealing thoughts, delusional perceptions and delusional influences, influence or overpowerment, hallucinatory voices commenting on or discussing the patient in the third person, thinking disorders and negative symptoms.

There is a negative opinion about schizophrenia in society. It manifests itself in the tendency to isolate the patients socially, and thus a kind of stigmatization of people suffering from the disease. They are denied their basic rights, including equal access to health services, treating them as inferior. [17-19]

IV. BIPOLAR AFFECTIVE DISORDER

Bipolar affective disorder is a recurrent bipolar affective disorder with depressive and maniacal episodes. Bipolar affective disorder (BAD) is a disease in which biological (genetic) factors play a more important role compared to (periodic) depression.

It is indicated that some of the genes predisposing to BAD may belong to a group of genes predisposing to schizophrenia. Genetic studies on BAD confirm some relationships between depressive disorders in relatives of people with bipolar affective disorders, although these relatives are more likely to have unipolar depressive disorders.

Diagnosis of bipolar affective disorder is based on the finding of maniacal or hypomaniacal syndrome in the patient at a given time. [14, 20] According to DSM-5, for the diagnosis of manic syndrome, apart from the persistently intense, expansive or irritable mood and increased activity or energy, the presence of at least three of the following seven symptoms is necessary [21]:

- a superior attitude;
- reduced need for sleep;
- excessive talkativeness;
- acceleration of the course of thinking;
- distraction;
- increased social, sexual or motor activity;
- involvement in pleasant activities that may cause unpleasant consequences.

It is common knowledge that the diagnostic management of mental disorders is considered individually. The same is true for BAD.

The therapeutic management depends on the clinical picture and severity of the disease. The following circumstances may form the basis for psychiatric hospitalization [7,9,10,12,13,15]:

- reckless behaviour that poses a risk to the patient or environment,
- severe psychotic symptoms,
- disability of criticism (e.g. reckless sexual contacts, profligacy,
- significant psychomotor excitement, threatening to cause injury, dehydration or exhaustion,
- he thinks about hurting himself or others.

It is indicated that patients with bipolar affective disorder during the health and depressive phases are more extrovert and impulsive than patients with unipolar course. Patients with bipolar affective disorder do not differ in most studies in terms of personality traits from healthy people, and ac-

cordingly, they are not more frequently affected by personality disorders. [7,9,12]

V. NEUROTIC DISORDERS (ANXIETY DISORDERS)

"...It can be assumed with a high degree of probability that there is no man of modern civilization who would not show clear neurotic symptoms for at least a short period of his life..." [10].

In modern psychiatric nomenclature, the term "neurotic disorders" has been replaced by "anxiety disorders". The term "neurosis" is slowly becoming obsolete; however, sometimes it is still used to describe milder forms of disorders more emotionally (psychologically) based. Anxiety disorders constitute a large group of mental disorders, including states previously called neuroses. It is believed that anxiety disorders are primarily emotional, associated with problems that begin in childhood, as well as the experience of traumatic events in the early years of life. It is assumed that the causes of anxiety disorders are difficult situations, conflicts which the patient is not able to solve on his own. "Symptoms are divided into mental, bodily and behavioural, they lead to increasing difficulties in relations with people and fulfilling certain social roles. Symptoms and ailments most often resemble and appear to be exacerbated and exaggerated reactions to difficult problems in healthy people. It is important to remember that anxiety can also be a symptom of many other diseases. [7,9,10,16]

The symptoms of anxiety or depression can overlap, e.g. difficulty in focusing attention, sleep disorders. Anxiety is particularly common in somatic diseases, hormonal disorders and in the course of cardiac diseases. Anxiety is a frequent companion in addictions, psychoactive poisoning, it also occurs as the main symptom of abstinence syndrome. In the case of anxiety, which is a symptom of a somatic disease, the basic disease should be treated first of all. Axiolytic drugs, acting symptomatically, only serve a supportive role, improving the patient's comfort of life. When anxiety is a derivative of addiction, an attempt at addiction therapy should be made. Sedatives should be used with caution as they may cause another addiction.[7,9,22]

Anxiety disorders on somatic grounds are most common as [14]:

- acute anxiety attacks, which may (but do not have to) meet the criteria of anxiety disorder with seizures (according to ICD-10),
- generalised anxiety / chronic anxiety, corresponding to the criteria of generalised anxiety disorder.

Due to the similarity of the somatic symptoms of anxiety and the symptoms of many life threatening situations, these states should be very carefully differentiated. This applies above all to emergency wards/reception rooms - especially in cases of a first-time panic attack. [10,14]

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